WC-365.1 (3-97)

State of New Jersey
Department of Labor
DIVISION OF WORKERS' COMPENSATION
CN 381

FROM

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## EMPLOYEE'S CLAIM PETITION SUPPLEMENTAL PAGE

	(DO NOT FILL IN)
CASE NO.	
D.O	

	Trenton, New Jersey 08625-0381		D.O	
			**************************************	
Date	e of Accident or Dates of Occupational Exposure:	If Re	spondent Known By Different	Name, Please Indicate Below:
	NAME (Indicate if Not Covered or self-insured)		NAME (Indicate if Not Covered or se	elf-insured)
I N C S A	NJ REG. OR FEIN		NJ REG. OR FEIN	
	ADDRESS	N C S A	ADDRESS	
URRR		U R R R		
A I N E		A I N E		
C R E		C R		
	PERIOD OF COVERAGE FROM TO		PERIOD OF COVERAGE FROM	ТО
	·		111011	
ı	NAME (Indicate if Not Covered or self-insured)		NAME (Indicate if Not Covered or se	elf-insured)
	NJ REG. OR FEIN		NJ REG. OR FEIN	
N C S A	ADDRESS	S A		
U R R R		U R R R		
A I N E		A I N E		
C R	CARRIER'S CLAIM FILE NUMBER	C R	CARRIER'S CLAIM FILE NUMBER	
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	PERIOD OF COVERAGE FROM TO		PERIOD OF COVERAGE FROM	то
	NAME (Indicate if Not Covered or self-insured) NJ REG. OR FEIN		NAME (Indicate if Not Covered or so NJ REG. OR FEIN	elf-insured)
I N C	ADDRESS	I N C	ADDRESS	
SAUR		S A		
RR		RR		
NE		NE		
C R E	CARRIER'S CLAIM FILE NUMBER	C R	CARRIER'S CLAIM FILE NUMBER	
	PERIOD OF COVERAGE		PERIOD OF COVERAGE	
	FROM TO		FROM	то
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	NAME (Indicate if Not Covered or self-insured) NJ REG. OR FEIN		NAME (Indicate if Not Covered or s NJ REG. OR FEIN	elf-insured)
	ADDRESS		ADDRESS	
S A U R		S A		
R R		RR		
N E		N E		
E	CARRIER'S CLAIM FILE NUMBER	E	CARRIER'S CLAIM FILE NUMBER	
	PERIOD OF COVERAGE		PERIOD OF COVERAGE	

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